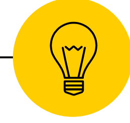
The Evolution of Patient Engagement: Experience-based Co-design in a Process Improvement Initiative



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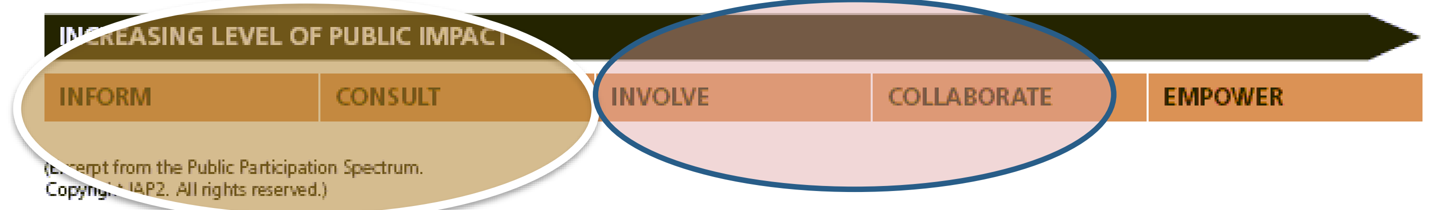
The Rationale for Engagement

- An effective way to deliver healthcare services
- Can improve the quality of care (Kwan, 2002)
- Impacts efficiency and health outcomes (Coulter A, Ellins J, 2007)
- Mechanism for discourse and analysis of the overall vision of the health system (Abelson & Eyles, 2002)
- Protects the public interest (Allen, 2000)
- Is the ‘right thing to do’

The Current State

- Limited primarily to priority setting and resource allocation (Mitton et al., 2009).
- Patient survey data a primary mechanism used to guide quality improvement efforts
- Sense of a need to evolve engagement:



IAP2 PUBLIC PARTICIPATION SPECTRUM

INCREASING LEVEL OF PUBLIC IMPACT

INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
Public Participation Goal:	**Public Participation Goal:**	**Public Participation Goal:**	**Public Participation Goal:**	**Public Participation Goal:**
To provide the public with balanced and objective information to assist them in understanding the problems, alternatives and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision, including the development of alternatives and the identification of the preferred solution.	To place final decision-making in the hands of the public.
Promise to the Public:	**Promise to the Public:**	**Promise to the Public:**	**Promise to the Public:**	**Promise to the Public:**
We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for direct advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.
Example Tools:	**Example Tools:**	**Example Tools:**	**Example Tools:**	**Example Tools:**
• fact sheets • web sites • open houses.	• public comment • focus groups • surveys • public meetings.	• workshops • deliberate polling.	• citizen advisory committees • consensus-building • participatory decision-making.	• citizen juries • ballots • delegated decisions.

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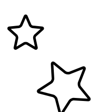

Evidence-based Co-design

- Focus on the experiences of patients/families and staff
- Observation, interviewing, experience/ emotional mapping
- Data analysis seeks to identify significant touchpoints for patients and which touchpoints had significant impact from a service perspective.
- Touchpoints elucidate key insights about the patient's experience of the service and care and collectively identify actions to improve the experience of patients

Research Design: Improving Patient Experience in an ED

- Participatory action research
- Semi-structured interview guide
- Focus groups with journey mapping
- *Accelerated*-EBCD trial utilizing UK guidance panels (Design Council)
- Framework approach

Accelerated-EBCD

Participants

Staff (Clinicians & Decision-makers)

Patients & Caregivers

Volunteers

Touchpoints

Initial point of contact

- When and where does it happen?
- Who: patients-staff-volunteers
- Registration or Triage
- Clinical or non-clinical issues

Wait time

- Determining WT Where to wait
- Committing to a service promise
- Concerns about caregiver time
- Queing concerns

Physical Design

- Access to information
- Physical flow of process
- Processing of ambulance bay patients
- Signage

Analysis

Information = power

anxiety

Nuisance

Touchpoints similar, perspectives diverse

SIGNAGE

Ad hoc
Complex
Confusing
Layout

TV
Clocks
Visual Access

PROCESS

Findings

1. A clear understanding of **wait-times** based on outlining the entire process to patients as they initially enter the ER is critical for both patients and staff.
2. Signage is a crucial determinant of patient experience in the ED context as vulnerable groups, including the elderly and frail, mental health consumers, visible minorities, those with lower education levels and the homeless, are frequent ED consumers.
3. Volunteers augmented the process. They were seen to be an intermediary in the patient-staff interaction. They mitigated issues with signage to relieve anxiety amongst patients and family members and stress for staff.
4. Disparities between staff and non-staff responses further suggests that incorporating EBCD is necessary for organizational commitment to patient engagement in decision-making and to further evolve levels of engagement.

Thank you

Dartmouth General patients, caregivers, clinicians, and staff
Patient and Public Engagement Unit, Capital District Health Authority
Dr. Catherine Loughlin, Saint Mary's University

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